NEW YORK SUPREME COURT - COUNTY OF BRONX
PART 23

Case Disposed ☐
Settle Order ☐
Schedule Appearance ☐

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

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Index #: **23144/14**

LUIS SAMUEL, as Administrator of the Estate of CAROL JONES-MOORE, Deceased and LUIS SAMUEL, individually,

DECISION/ORDER

Plaintiffs,

- against -

Present:
Hon. Joseph E. Capella
J.S.C.

THE ST. JOHN'S RIVERSIDE HOSPITAL, DOMINICK ARTUSO, DOMINICK ARTUSO, M.D., P.C., JO ANN MICHAELSEN, STEVEN BARRY, DEREK SOOHOO and ENT AND ALLERGY ASSOC. LLP,

Defendants.

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The following papers numbered 1 to 2 read on this motion.

PAPERS	NUMBERED
NOTICE OF MOTION AND CROSS MOTION	1
ANSWERING AFFIDAVIT AND EXHIBITS	2
REPLY AFFIDAVIT AND EXHIBITS	–

UPON THE FOREGOING CITED PAPERS, THE DECISION/ORDER IN THIS MOTION IS AS FOLLOWS:

Defendants, Dominick Artuso and Dominick Artuso M.D., P.C., seek summary judgment (CPLR 3212) and dismissal of the instant medical malpractice and wrongful death action. The complaint alleges, in sum and substance, that defendants failed to obtain informed consent and failed adequately treat an infection that developed in decedent's lap band and lap band port, resulting in her suffering a stroke that lead to her death. It is defendants' burden, as the movant for summary judgment, to make a *prima*

facie showing of an entitlement to same as a matter of law by tendering sufficient evidence to eliminate any material issues of fact. (*Alvarez v Prospect*, 68 NY2d 320 [1986].) In other words, defendants must provide evidentiary proof in the form of expert opinion(s) and/or factual evidence that establishes that defendants did not deviate from accepted standards of care and practice, and as such, their conduct was not a proximate cause of the alleged injuries. (*Fileccia v Massapequa*, 99 AD2d 796 [2nd Dept 1984]; *affirmed* 63 NY2d 639 [1984].) If defendants do, then the burden shifts to plaintiffs to produce evidentiary proof in admissible form sufficient to create issues of fact to warrant a trial (*Alvarez*, 68 NY2d 320), and denial of summary judgment.

On March 3, 2003, Dr. Artuso performed laparoscopic gastric band placement on decedent to address her obesity. Besides placing a lap band around the stomach, a small device called a port was placed under the abdomen's skin. It was connected by tubing to the lap band to allow Dr. Artuso to periodically adjust the tightness of the band by injecting or removing saline water into or from the port. Over the years, decedent routinely followed up with Dr. Artuso for adjustments to the gastric band. On January 23, 2012, decedent met with Dr. Artuso complaining of severe pain near her port site, and a CT scan revealed a hiatal hernia and inflammation. On March 12, 2012, decedent visited Dr. Artuso and indicated that all pain at the port site had resolved. The next day, March 13, decedent returned complaining that the band was too tight, and when Nurse Michaelsen attempted to aspirate fluid from the port, purulent liquid came into the

syringe. Lab results revealed no organisms seen, no polymorphonuclear WBCs observed, and no growth of aerobic organisms after 48 hours. Decedent was prescribed Bactrim DS for 14 days.

On March 19, 2012, decedent went to St. John's Riverside Hospital (SJR) ER experiencing abdominal pain, fever and chills. The wound was aspirated and cultured. Dr. Artuso saw decedent in the ER and noted an enlarging left sided abdominal mass in the vicinity of the port. Later that day he surgically removed the infected subcutaneous gastric port component, and drained the abdominal wall abscess. Decedent was later discharged home. Over the next several weeks, decedent visited Dr. Artuso's office and Westchester Digestive Disease Group for follow up treatments. On April 26, 2012, decedent returned to Dr. Artuso's office for wound care, when it was noted that the incision was closing and would not hold a wick. There was a strong fishy odor, and Nurse Michaelsen sent a culture to the hospital for analysis. Lab results were received on April 30 indicating the presence of pseudomonas and staphylococcus. On May 9, Dr. Artuso admitted decedent to SJR for an abdominal abscess, and she was discharged on May 14.

On May 31, decedent returned to Dr. Artuso's office to have her incision checked, which revealed a small amount of drainage. She was told that if the situation did not improve by June 4, she should return for possible removal of the lap band. On June 1, decedent was admitted to SJR ER for abdominal pain, at which point Dr. Artuso

performed surgery to remove the lap band. Massive amounts of scar tissue were noted, and it appeared that the omentum had walled off the lap band from the rest of the abdominal cavity. On June 13, after several days of treatment at SJR, Dr. Steven Barry, an infectious disease expert, determined that the infection had resolved and decedent was discharged. On June 16, decedent was brought to SJR ER by ambulance for right sided weakness and droop. She was diagnosed with intracranial and subarachnoid hemorrhage, and transferred to Westchester Medical Center ER, where she remained until August 2012. In August 2012, decedent was transferred to Regency Extended Care Center, where she remained until August 2013. She was then transferred to St. Joseph's Nursing Home, where she died on December 12, 2013.

In support of their motion, defendants include an expert affidavit by Dr. Andrew Larson, who is board certified in general, laparoscopic and bariatric surgery. Dr. Larson opines that Dr. Artuso's care was completely appropriate and well within the prevailing standard of care for a bariatric surgeon managing a lap band apparatus and treating post-surgical infection. According to Dr. Larson, decedent's initial clinical course argued against infection. On March 13, 2012, decedent returned to Dr. Artuso with swelling noted at the port site, and aspiration of the region of the port caused purulent fluid to return into the syringe. It was at this point that Dr. Artuso would have had any cause for concern, and so he appropriately ordered lab tests, a further CT scan, and started oral antibiotics. On March 19, at SJR's ER, more aggressive intervention was required, and in

accordance with the standard of care, Dr. Artuso removed the port and left the wound open with packing so that it could gradually heal as the infection resolved.

The lab results received on April 30 revealed the presence of pseudomonas and staphylococcus bacteria, and according to Dr. Larson, Dr. Artuso appropriately referred decedent to Dr. Barry, an infectious disease expert who administered more powerful antibiotics. Dr. Larson notes that by May 14, all indications were that decedent's infection had resolved. According to Dr. Larson, lap band removal is a major abdominal surgery with it own set of risks. He goes on to state that there is a clear contraindication to perform a lap band removal until less invasive and less consequential treatments have proven ineffective. It is his opinion that only on June 1 did the risk of persistent uncontrolled infection outweigh the risk of surgically removing the lap band. He goes on to note that decedent was appropriately treated with antibiotics following the lap band removal, and on June 13, decedent was discharged home. And when decedent returned to SJR three days later, there were no residual signs of infection, and her white blood count was normal.

Dr. Larson notes that decedent went on to suffer a major stroke from which she did not recover, and intracranial venous thrombosis seems to be the precipitating cause. She had numerous risk factors to stroke, including severe morbid obesity, hypertension, a pituitary tumor and hypercoagulability due to recent surgery. According to Dr. Larson, despite the best of medical care, strokes will occur in high risk patients, and this does not

reflect substandard care, but rather the human conditions that cause most of these events. Lastly, Dr. Larson concludes that Dr. Artuso adequately informed decedent of the risks, benefits and alternatives to her treatment. Based on the aforementioned, the Court is satisfied that defendants have met their burden for summary judgment, (*Zuckerman v City of NY*, 49 NY2d 557 [1980]; *Kaffka v NY Hospital*, 228 AD2d 332 [1st Dept 1996]), which now shifts to plaintiffs to demonstrate that issues of fact exist to warrant a trial.

In opposition, plaintiffs submit an expert affidavit from a board certified general surgeon. He states that on March 13, after NP Michaelsen aspirated purulent fluid from the port, Dr. Artuso decided to remove the port only, even though he was well aware that if the port was infected, the entire lap band was likely infected as well. On March 19, Dr. Artuso encountered a lot of drainage of purulent fluid from an abscess when he made his incision at the port. Plaintiffs' expert opines that Dr. Artuso exposed the lap band's tubing to the infected area before returning it into decedent's abdomen. He goes on to state that Dr. Artuso did not inform decedent of the alternative option of completely removing the lap band. He notes that on March 26, Dr. Artuso noted slight drainage of the wound even though decedent was on antibiotics, and on April 26, NP Michaelson noted a strong fishy odor. On April 30, the culture showed significant infection, and on May 9 and 17, green drainage continued to come from the wound. On May 31, decedent returned to Dr. Artuso's office complaining that she did not feel better, and on June 1, the lap band was removed. Plaintiffs' expert states that where a post-operative patient

displays such signs and symptoms of an infected lap band, good and accepted practice requires the bariatric surgeon to assume unless proven otherwise that the lap band is infected requiring removal as soon as possible.

Plaintiffs' expert opines that Dr. Artuso should have realized that the entire lap band needed to come out both prior to and during the March 19 surgery. He states that persistence of wound drainage, fever, chills, abdominal pain and incomplete healing of the wound clearly indicated that there was an ongoing infection that port removal alone did not and could not resolve. It is the surgeon's opinion that these departures were a "significant factor contributing to the exacerbation of the infection . . . permitt[ing] it to advance unchecked to a dangerous and life-threatening stage." Plaintiffs also provide an expert affidavit from a board certified neurologist, who provides a similar analysis and opines that "had the infection been avioded or successfully treated earlier, this devastating event, its sequelae, and [decedent's] death would not have occurred." Viewing the evidence in a light most favorable to plaintiffs, (*O'Sullivan v Presbyterian*, 217 AD2d 98 [1st Dept 1995]), these experts disagree on material issues of fact regarding whether there was a departure and proximate cause (*Alvarez v Prospect*, 68 NY2d 320 [1986]) – issues must be resolved by the trier of fact. (*Barnett v Fashakin,* 85 AD3d 832 [2nd Dept 2011]; *Frye v Montefiore*, 70 AD3d 15 [1st Dept 2009]). The trier of fact will hear from these experts, including the evidence that each one relies upon in forming the basis for their expert opinion, and in turn they will evaluate the weight and credibility of the testimony

of these experts. (*Cassano v Hagstrom*, 5 NY2d 643 [1959]; *State v Marks*, 87 AD3d 73 [3rd Dept 2011].) Therefore, defendants' motion for summary judgment is denied accordingly. Plaintiffs are directed to serve a copy of this decision with notice of entry by first class mail upon all sides within 30 days of receipt of copy of same. This constitutes the decision and order of this court.

12/14/21
Dated

Hon. _____
Joseph E. Capella, J.S.C.